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ABSTRACT

Residential care must be redefined, free from jargon and rhetoric. Over the past 20 years, the social welfare approach, which encompasses the medical model, has dominated legislative and practical thinking about residential care. This theoretical thinking reached its culmination in the concept of the therapeutic community. The therapeutic community is based on democratisation and permissiveness, supported by reality confrontation and communalism. However, in practice, the ideal of each member in the community sharing equally in the exercise of power in decision making about community affairs cannot happen without deleterious consequences. The democracy of the therapeutic community is at best a pretense. Residential care must think anew about the problematic elements in the therapeutic community of diffusion of authority and responsibility. A balance must be struck between the power of those exercising authority and the freedom of those subject to it. The primary task of residential care is to provide a living situation which meets the physical, emotional, intellectual, and spiritual needs of the residents. The facility must nurture its residents. Residential care depends on a professional assessment of need and a professional application of a planned program to meet that need. Residential care must develop a cogent philosophy, a relevant theoretical model, and a program of practice based on both. (BL)

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RESIDENTIAL CARE: BACK TO FIRST PRINCIPLES

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RESIDENTIAL CARE - BACK TO FIRST PRINCIPLES

It is understandable that Orwell's "Nineteen Eighty Four" should receive a renewed and wider attention in this particular year. Clearly, it is primarily a political novel; a novel which has been used by polemicists of the right and left of the political spectrum, to support diametrically opposite positions. At the same time it carries another message which is of more general application; a message which has special relevance for this conference. It concerns the proper use of language.

At best, language is the means by which thought is conducted; at worst it may be used to control thought, to limit it, to distort reality. At a time when residential care is under closer scrutiny and, in some quarters, attack, than ever before, at a time when "alternative strategies to residential care" are being called for, (Tutt 1978) and when strategies may be of dubious validity (Cohen 1979) then it is time for residential care to return to its roots. It is time to attempt a statement concerning residential care in simple language free from jargon and rhetoric. It would seem appropriate that such an attempt be made at a conference devoted to group work practice.

The above reference to Orwell is more than a literary device. Since the second world war the language of residential care has changed markedly. But changes in language have not always led to clearer understanding. Nowhere is this better illustrated than in the residential care for children and young people.

The thinking of theorists, legislators and many practitioners has, in the last twenty years or more, been dominated by the social welfare approach. Within this approach the medical model was pre-eminent, 'treatment' and 'therapy' became the catchwords of the new dispensation. A study of the Social Work (Scotland) Act 1968, the Children and Young Persons Act of 1969, and their satellite documents will show this. In these documents there are examples of the concepts of one model, with all their assumptions and implications, being used as if they were interchangeable with the concepts of a different model with a different set of assumptions and implications. In addition, the language used persisted in its lack of definition and precision. It was, and for the most part remains, ambiguous and inappropriate. As Morris and McIsaac (1978) pointed out the "analogy with medicine is unsound" - a view supported by Balbernie (1975).

In medicine, treatment is defined as "the management of remedies". It is pertinent for those working in residential care to ask whether there is remedy for old age? Is there a cure for delinquency? On this topic Allen (1964) wrote that "good intentions and a flexible vocabulary do not alter the reality" and more trenchantly "the language of therapy has frequently provided a formidable obstacle to a realistic analysis of the conditions that confront us." Against this background the 'therapeutic community,' which became the organisational paradigm, merits closer scrutiny.

Dr Mason of the Children's Department at the Home Office saw the progress of

residential care reaching its culmination in the "concept of the therapeutic community". She does not however, offer a precise defininition of such a community. The nearest she comes to it is:

> "The general regime is not of old fashioned, uninformed discipline, nor of the limited authoritarian approach, nor of a misunderstood permissiveness and lack of order, but of a therapeutic community where, with knowledge and understanding of all staff, a structure can be created, limits can be set and maintained, in which greater freedom and personal development can take place."
> (Mason 1968)

The Advisory Council on Child Care (1970) offered a slighty better definition:

> "A therapeutic environment is one in which informal communication is encouraged, where there is an understanding of deviant behaviour, where the child has the opportunity to express symptoms of his disturbance and where children accept their share of responsibility for helping others."

Maxwell Jones (1956), one of the authorities on the concept, stresses the patients' responsibility for mutual help and the importance of communication. For him "the community meeting epitomises the function of the therapeutic community. Its aim is to achieve the fullest possible expression of feelings by

both patients and staff."

It is Rapport (1960) who gives the most thorough analysis of the concept and of its practicality. He states that the fundamental character of a therapeutic community is based on three general propositions: a) everything is treatment; b) all treatment is rehabilitative; c) all members should receive the same treatment. The key concepts of the above are democratisation and permissiveness supported by the notions of reality confrontation and communalism

> "Democratisation means that each member of the community should share equally in the excercise of power in decision making about community affairs, both therapeutic and administrative" (Rapport 1960)

In practice this does not happen; in practice it cannot happen without serious deleterious consequences. It is in this area of treatment that rhetoric abounds. The democracy of the therapeutic community is at best a pretence, at worst an intellectual confidence trick (Wills 1941). The problematic elements are concerned with the diffusion of authority and responsibility.

Within the framework of the therapeutic community it is assumed that permissiveness and tolerance lead to a greater understanding (Home Office 1970): an assumption open to question. As Rapport (1960) makes clear, it is a view most strongly held by senior and specialist staff and by the "experts without". It is a view more easily sustained in theory than in practice, in general than in

particular. For those who are charged with translating theory into practice and are constantly interacting with the inmates, patients or delinquents, the case is problematic. In practice, when boundaries are threatened or limits breached, an authoritative intervention is necessary and appropriate. "The abdication of the responsible exercise of power in situations where it is appropriate has been shown to be therapeutically harmful" (Rapport 1960).

Reality confrontation is glossed over in practice because it conflicts too directly with the general view that to be effective therapy must be permissive. Conflict situations are most often solved by the direct intervention of authority - a concept usually ignored by proponents of the therapeutic community. For staff of a residential institution a fundamental lesson to be learned is that sometimes the answer is 'NO' and that at times intolerance is the appropriate response.

The last mentioned communalism, receives little consideration, partly because in the context of any residential care institution it is likely to prove an impossibility.

"One cause of confusion is due, in part, to the too imprecise and apparently interchangeable use of terms." (Zeitlyn 1967). The therapeutic community was seen as the best possible response to authoritarian regimes. (Mason 1968) Because its nature is so vague, it became all things to all men. "Indeed, Maxwell Jones in his definition appears to retreat to so general a standpoint as to suggest that there is no 'proper' therapeutic community at all"(Zeitlyn 1967).

Those familiar with good residential practice might be forgiven for asking 'but

what is therapy'? A further quote from Orwell might well fit the bill - he wrote in another context of "a ramshackle abstraction inviting everyone to come in and stop thinking for a while."

The implication of this paper is that for residential care it is time to start thinking again. As indicated above, the problematic elements in the concept of the therapeutic community are a diffusion of authority and responsibility. This is a good place to start.

In any residential institution the two major groups are the residents and the staff. It is a reasonable assumption that because of the very nature of the institution, the residents are in a state of dependence on the staff. In this sense, the residents are the subordinate group and the staff is the group exercisin power. More simply, the staff are in a position of authority over the residents.

From an organisational stance the matter may be stated in a slighty different way. In any institution rules are necessary; these have to be enforced and thus social control arises. Social control involves acts of authority. It is in the nature of authority that one or more people exercise legitimate power over one or more others. It is also in the nature of authority, properly exercised, that those subject to it recognise the need for it, accept it, and in this way they, the subjects, legitimise the power practised over them. The balance to be struck is between the power of those exercising authority and the freedom of those subject to it.

Those in authority must endeavour to be authoritative but not authoritarian (Peters 1973). In any residential institution, it is formally and explicitily invested in the staff, who may share it informally with the residents. They cannot share it as equals, nor dispense with it altogether (Rapport 1960). Not all adults exercise equal authority; the authority of each is commensurate with the level of responsibility required of each. Many are eager to have greater authority but few wish to accept an equal level of responsibility. For others authority exercised contrary to their wishes is labelled authoritarian. Authority may be delegated; it may be shared; but it cannot be shared equally by all. To suggest otherwise is deluding and confusing. It is more open and honest to be explicit about the authority structure because that is part of reality.

The exercise of authority is full of paradoxes. It must be exercised by staff so that residents can learn to do without it. Those who clamour most for more authority are usually those who show least expertise in its exercise; and those who are most sure of their authority have least need to display it. For authority to be appropriate, its structure must be relevant to those for whom it exists and germane to the task of the institution. In this way authority is rationalised and, as long as it remains so, it will not become authoritarian.

The majority of children and young people in residential care are, according to Millham (1981) "among the casualties of other interventions and consequently the most difficult; the failures of the education, day care, family services, community supervision and those who fail to settle into foster homes."

It is because these youngsters are "too young, too damaged and too immature" (Kahan 1967), that a democratic structure is inappropriate for them.

Authority strictly related to the task is rationalised thereby; exercised simply as an expression of status or as an instrument of domination, it justifiable merits the epithet authoritarian. The authoritarian person is one who takes delight in giving orders, makes rules for their own sake and provides backing for the rules by appeal to status. In any institution, those who exercise authority may become authoritarian.

Regular meetings of the full community, properly managed, provide a safe-guard against such developments. Each meeting is a forum where each member is accountable to the community. But the best defence against authority degenerating into authoritarianism is to ensure a close correlation between authority and task or, that these two be in a state of mutual interdependence. It follows that not only is a proper understanding of authority a pre-requisite of residential care but it must be allied to a precise definition of the task.

The primary task of residential care is to provide a living situation which meets the physical, emotional, intellectual and spiritual needs of the residents. Everything that happens in the institution is relevant to this task even when the relevance might be negative. Housing, feeding, clothing, sleeping, recreation and the like, are pertinent to the job in hand and not simply "those few experiences solemnly put aside and labelled "treatment" (Jones 1968). The basic aspects of the task may be described as a curriculum of nurture and

care to which other subsidiary tasks may be added eg children and young people in care have a right to education.

Nurture is concerned with physical growth and well-being and requires careful attention to food, clothing, warmth and living conditions. A balance must be struck between the imposition of inappropriate standards and the need to present the residents with a positive statement as to how they are seen. The imposition of middle class standards on youngsters from working class backgrounds is a charge sometimes levelled at residential establishments and should be answered. Standards of feeding and cleanliness are to be judged by what is required by good health; standards of furniture should not be extravagant but of good quality, if only because the youngsters should have good quality as a positive statement about their own worth. Finally, social interaction is made more effective if rules of good conduct are observed. In general, there is a greater degree of agreement on such matters than is sometimes acknowledged.

The second part of the above proposition should be emphasised; it implies a clear appreciation of the importance of the messages given to residents, indirectly and often unconsciously; what might be referred to as the hidden agenda of the curriculum. One aspect of nurture merits more detailed attention because, by design and practice, it should be a central fact of the life of the institution. In many ways it encapsulates what the institution stands for. This aspect is that of food.

The importance of food in the scheme of residential care is not always understood. It is taken for granted and, as a result, its full implications are lost. Very little appears in the literature concerning food. Goffman (1964) refers to meals only as providing opportunities for secondary adjustment through obtaining "stashes". Millham et al (1975) comments on the "relaxed, informal meal times" of family group homes and little more. In one school studied by Giller (1979) "boys queued for food while one man walked up and down supervising". In another, one member of staff sat at his own dining table facing the body of the room. When asked why he did not eat with the boys he replied "Because you look after pigs, does not mean that you have to eat with them". Bramham (1980) suggests that meal times offer scope for subtle distinctions to be made between boys and staff "Staff eat separately from boys, have tablecloths and meals are served for them.....staff have butter, boys have margarine....."

The positive aspects remain unrecognised. The need is so basic that not only is its full significance missed but meal times become parts of the day to be got through as quickly as possible and with minimum fuss.

The new provision of good adequate meals, eaten together, allows residents and staff to use meal times as a shared experience of great significance. Meal times then, are a practical and daily comment on the concept of community. All members are equal at table and the emphasis is on sharing not on status. Their importance - meal times - transcends the simple eating of food. The insistence on commensality - the habit of eating at the same table - if, built into

the structure pays dividends in all other aspects of life for residents and staff.

> "Eating together', as Dr Johnson would say, 'promotes good will, Sir, commensality is benevolent"'
> (Oxford Dictionary 1825)

The Barclay report (1983) offers a sympathetic but sound analysis of residential care. It refers to nurture under the heading of "tending" which may be a more subtle term if only because it is less clinical. In developing the scope of tending the report makes it explicit that all those in daily contact with the residents are part of the caring team. "Often it is in the round of daily and common tasks that real sharing, communication and understanding occurs. Tending activities not only convey clear messages but also are the focus of intense feelings related to conflict between control and freedom, dependence and independence, self esteem and self disgust" (Barclay 1983). For the staff in residential care this view has two implications:

1. that each should recognise the importance of his/her contribution to the caring task.
2. that having recognised this, each should become more aware of the opportunities offered by the "round of daily and common tasks".

Care is mediated through good tending practice not superimposed upon them. The caring task has obvious professional aspects which Barclay helps to identify as social care planning and counselling. The former consists of planning and organising a response to existing problems plus arrangements for the future. Counselling is defined as "the process of direct communication and interaction between clients and social workers through which clients are

helped to change or to tolerate some aspects of themselves or of their environment".

Whatever the shortcomings of the Barclay report, it is to be commended for its tacit attempt to de-mystify aspects of social work like counselling. Within residential institutions it is important that the responsibility for each resident be formally vested in a named member of staff. Such a person may be described as the key worker or as mentor, counsellor, adviser; whichever description is used, the fact is, that each resident will benefit from the unconditional commitment of a staff member. For the organisation too, it is both good practice and good management to have a specific member of staff responsible for each resident.

According to Righton (1966) residential care depends on "the application of appropriate specialised skill to the point of identified need, adapted and modified as needs change". For Beedell (1969) what is crucial is "the sharing in the undefended encounter of our plans, hopes, doubts and fears with the children". For residential workers the task should be spelt out in terms which reflect the meaning of both these questions.

Residential care depends on two major factors; firstly, a professional assessment of need and a professional application of a planned programme to meet that need, both assessment and programme being regularly reviewed and

amended in the light of experience. The second factor is more concerned with attitudes of staff and residents. It demands from all members of the community a degree of honesty, openness and sensitivity which are pre-requisites for effective care.

It is worth making explicit that the residential care task is a difficult one at times even "an impossible task" (Barclay 1983). Unfortunately "the excellence of much of our residential work passes unacknowledged; the difficulty of residential living is not sufficiently understood and the present training situation remains unsatisfactory" (Millham 1981). Effective residential care demands people of quality who can survive, who show tenacity and who can cope with frequent rejection. At rock bottom it involves people working with other people; people doing things to, for, and with others, the emphasis varying according to circumstances of time place and need.

Residential care operates in an institutional framework containing two major groups, the residents and the staff. It should be the aim of the institution to function as a community - a social entity with a common identity. To achieve this requires a cogent philosophy, a relevant theoretical model and a programme of practice informed by the philosophy and based on the theory. By no means all institutions achieve this for within the framework there are forces at work which are anti-task. Those involved in residential care, especially in management, must be aware of such forces and the consequent

tensions. Goffman (1968) in "Asylums", the classic study of a total institution, provides a vivid account of the dichotomy which may occur between residents and staff through "secondary adjustments". In this work he sets out the dimensions of staff power; use of coercion, reward systems, control of time, control of space, control of information; these dimensions may be used to maintain the staff groups disconnection from the residents. Clearly the role of management is critical at this point, not only is it responsible for defining the task but it must also organise the resources of the institution in such a way as to achieve this task - a task defined in the first instance by the needs of the residents.

Lambert et al (1970) offers an analysis of the institution in terms of these needs defined as:

Expressive goals (security, affection, warmth)

Instrumental goals (self protection, success, progress)

Organisational goals (domestic needs, social life, preparation of food)

This study demonstrates that organisational goals tend to displace the others and in turn lead to institutionalisation. Simply put, the needs of the institution as an organisation becomes more important than the needs of those for whom the institution exists. In different language, the power of authority is used to maintain the organisation, in opposition to the real task, or the regime becomes authoritarian. In extreme cases, such regimes lead to a "violent and repressive inmate culture" (Millham et al 1981) or they lead to such a dichotomy between residents and staff that each group operates at the most basic level as if it were independent of the other (Goffman 1968).

Earlier in this paper, reference was made to 'forces' at work which are anti-task, a comment which requires elucidation. It is hoped, by doing so, to demonstrate the necessity for those in residential care to understand the nature of group behaviour. Such a view is supported by Thelen (1960) who wrote that 'most of us working with people in groups would improve remarkably if we could suddenly understand all we know.'

It was C S Cooley who first introduced the notion of primary and secondary groups and highlighted their major differences. There is now available a wide variety of works on the subject. Crucial to the understanding of group behaviour is the recognition that it operates on two distinct levels - the conscious and the unconscious. Of all the work to hand on group dynamics that of Bion 'is fundamental to all group work' (Ottaway 1966). Time and space allows for only a mere summary of his work.

Operating at the conscious level is the work group which meets for a specific purpose and is organised to that end. Within it, the need for growth and development is recognised and its operation as a work group is constrained by the task and by time.

At the same time, the group is functioning at an unconscious level, and is always influencing the operation of the work group. The energies of the group at this level are concerned with emotions so powerful that the behaviour of the group is often irrational; sometimes the activity will coincide with the work groups, but more often it will be in conflict with the stated aims of the group.

It is in this sense that the forces are 'anti-task'. To help 'to give form or meaning to the complex and chaotic emotional state that the group unfolds,' Bion postulated his theory of basic assumptions. These are three in number, and singly or together, they form the foundations of the group's unconscious activities. They are:

dependency: the group seeks to obtain security by placing itself in the hands of a leader whom the group considers to be dependable. The leader chosen is not necessarily the leader of the work group.

pairing: the group seeks continuity and hope by seeking to reproduce itself through the illusion that two members of the group can produce a solution to the group's problems.

fight/flight: the group seeks to preserve itself by aggression towards anyone who endangers the group or by avoiding and ignoring the threat.

All groups operate on these basic assumptions at the unconscious level where they are concerned with, often unacknowledged, feelings of anxiety, guilt, power and struggles and jealousies. Because they are unconscious it is difficult to observe and understand them except by careful observation: even then, the observer may be caught up in the very processes he seeks to unravel. However, even the least experienced observer will be aware of how much the time and energy of the group is wasted on matters which are irrelevant to the task. Such

behaviour is the result of the 'unwritten agenda' of the basic assumptions.

What has been written applies to all groups. It is within the small group that the individual internalises the appropriate norms and values. The larger the group, the greater and more complex are the mechanics of the basic assumptions. The large group will more easily fall prey to the strivings of individuals and may be subjected to a diversity of small groups within it.

Since residential care is by its very nature an exercise in group care, the need for those involved to have an understanding of group dynamics is evident. Those in positions of management have a particular responsibility in this regard. It is for them to define the task and set out its boundaries; to organise the resources available to achieve the task: to maintain a constant review of its definition and constraints; and to manage the relations between the institution and its external environment. In addition, the management must be sensitive to the feelings and attitudes of those sharing the same task; show the ability to understand the group processes at the conscious and unconscious level: and possess the skill to stick to the task.

Finally, the success of the work group in carrying out its task is dependant on good communication. The language of the basic assumption group is debased and lacks precision (Bion). It leads to confusion and the negation of the task. It is essential for the work group to be in touch with reality, which can only be assured by the precise use of language. Nineteen eighty four is an appropriate year to be reminded of this.

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